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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **CAMILLE A. CROMWELL** **6540 El Camino del Teatro** **La Jolla, CA 92037** **Registered Nurse License No. 788702** Respondent.	Case No. 2013-839 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about December 27, 2010, the Board of Registered Nursing issued Registered Nurse License Number 788702 to Camille A. Cromwell (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2014, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISION

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
>
> . . . .

REGULATORY PROVISIONS

7. Title 16, California Code of Regulations, section 1442, states:

> As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

8. Title 16, California Code of Regulations, section 1443, states:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

9. Title 16, California Code of Regulations, section 1443.5, states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COSTS

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement

FACTUAL ALLEGATIONS

11. In December of 2010, Respondent was hired to work as an RN at Sharp Staffing Resource Network where she worked in the emergency rooms of the various Sharp facilities.

12. On August 25, 2011, MM, a 35 year old woman, was brought by paramedics to Sharp Grossmont Hospital with a chief complaint of abdominal pain.

13. Upon admission, MM reported to Respondent that she was a "hard stick."

14. MM has a history of bilateral mastectomies with breast reconstruction.

15. Without trying other access sites, Respondent placed a 20 gauge IV into MM's right breast vein on her first attempt. There was no documentation supporting Respondent's decision to place the IV in the right breast and there was no evidence of a discussion with the ER physician regarding such placement.

16. The CT Technician questioned Respondent about the IV placement. There was no documentation concerning the CT technician's alleged concern over IV contrast for CT abdomen utilizing a right breast vein. A technician ultimately performed the CT.

17. After the CT was performed, a Physician spoke to MM about the results of the tests and instructed her to follow up with her surgeon and primary care physician about her abdominal pain.

18. The hospital's policy assigns responsibility for discharge to either an RN or LVN. When an LVN came to the room to discharge her, MM was already dressed. The IV remained in MM's right breast and was not visible to the LVN. The LVN reviewed the discharge instructions with MM. The discharge instructions do not refer to IV removal.

19. MM, who was groggy from the medication she was given, was not aware that the IV was in place upon her discharge home and did not discover it until she woke up the next day. When she noticed the IV, she called the doctor who told her to go to the hospital to have it removed, but she was too groggy to drive and did not go to the hospital that day.

20. A few moments after her discharge, Respondent discovered that MM was discharged with the IV still intact. She called security to see if they could stop MM in the parking lot and she tried to call MM. A note in the file titled "Emergency Documentation" entered by Respondent on

September 2, 2011, indicated "Pt left ER without having IV removed. Pt was dressed when nurse went into room for DC. Security sent to parking to look for pt, message left for pt at her home. ED manager notified." Because she did not return to her own home after the hospital, MM did not get this message until days later.

21. On August 27, 2011, MM went to Sharp Chula Vista with a chief complaint of right breast pain secondary to the IV placed at Sharp Grossmont on August 25, 2011. She was examined, given an ultrasound of her right breast, and the IV was removed, a painful process.

22. MM was discharged with a diagnosis of possible mild cellulitis at the IV site and chronic abdominal pain. She was placed on clindamycin, an antibiotic to cover the possible cellulitis. Breast ultrasound and other diagnositics were benign. There was no evidence of right breast abscess per the ultrasound results.

23. On September 2, 2011, MM filed a complaint with the Nursing Board against Respondent for causing her harm.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

24. Respondent has subjected her registered nurse license to disciplinary action for unprofessional conduct under section 2761, subdivision (a)(1) in that she was grossly negligent, as defined by Title 16, California Code of Regulations, section 1442, as detailed in paragraphs 11 to 23 which are incorporated herein by reference. Respondent's actions demonstrated an extreme departure from the standard of care in the area of IV therapy as described above and in the following ways:

25. Respondent placed an IV in MM's right breast vein without adequate evaluation, assessment, and documentation supporting such placement. There was no documentation demonstrating that all other avenues for IV access had been exhausted before placement in the breast vein. This was not a life threatening emergency requiring IV access deviating from the standards of care. There was only one attempt at IV access, and it was successful. The use of a breast vein should only be reserved for situations in which all other avenues for IV access have been exhausted and the choice of that access site should be supported in the patient's record.

25. There was no documentation that the ER Physician was informed as to utilizing a breast vein for access. The ER Physician should have been consulted and issued an order for placement in an unusual vein insertion site, especially given MM's extensive medical history and abdominal pain presentation such that CT with IV contrast should have been anticipated.

26. There was a potential for patient harm with the placement of the IV in MM's right breast vein. MM has a history of bilateral mastectomies with breast reconstruction, which contradicts the use of her right breast for IV access. CT injection further increased this potential for harm.

27. Respondent was also grossly negligent in leaving the IV in the breast vein when the patient was discharged from the hospital. The IV should have been removed and the IV site assessed upon removal and documentation of that assessment placed in the medical record. Respondent had the obligation to communicate fully to the LVN the status of the patient prior to the discharge process. Telling the LVN that the patient was "ready for discharge" places an assumption that the assessment was completed, which is not supported by the medical record. There is no transfer of care documentation in the file from that day.

28. Leaving an IV in the breast of a patient who is discharged from the hospital has the potential to harm the patient. The resultant mild cellulitis post IV retention could have been avoided if Respondent followed the accepted discharge process. Respondent, as the primary care RN, had the responsibility to either address the IV herself or hand off the information about the IV to the LVN on duty upon the transfer of care.

29. There is no contemporaneous documentation regarding the status of the IV, site location, or the IV being left in place during the discharge process. There was a late entry on September 2, 2011, with a description of the remediation actions by Respondent. There was no documentation in regards to the effectiveness of Respondent's efforts to communicate with MM or any documentation of follow up with MM. Given the fact that Respondent was unable to directly communicate with MM about the IV being left in her breast, she had the responsibility to ensure that follow up actions and intervention took place to protect her patient. Other than leaving the patient a message, no further action took place. The community standard is to contact

local law enforcement to visit the patient to alert the patient to return to the ER, so that harm may be avoided. This did not occur.

30. There was a lack of documentation throughout the ER encounter with the RN. For instance, IV fluids were ordered, but it is unclear the status of fluids received and whether or not the IV was reconnected post CT.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

31. Respondent has subjected her registered nurse license to disciplinary action for unprofessional conduct under section 2761, subdivision (a)(1) in that she was incompetent, as defined by Title 16, California Code of Regulations, section 1443. Respondent failed to exercise the degree of learning, skill, care and experience ordinarily possessed and exercised by a competent RN in the areas of IV therapy, nursing assessment, evaluation, and documentation as detailed in paragraphs 11 to 30 which are incorporated herein by reference.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 788702, issued to Camille A. Cromwell;

2. Ordering Camille A. Cromwell to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: March 27, 2013

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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